

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040998

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3168

FILED NOV 5 1962

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in lb <b>1 Day</b>	c. CITY OR TOWN <b>St. Johns</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Marys Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8836 St. Charles Rd.</b>
3. NAME OF DECEASED (Type or print) First <b>Leo</b> Middle <b>S.</b> Last <b>Ellebracht</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> , Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/15/1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Inspector</b>	9. AGE (last birthday) <b>69</b>
11a. FATHER'S NAME <b>Arnold Ellebracht</b>		11b. BIRTHPLACE (City and state or country) <b>Florissant Mo.</b>	
13a. FATHER'S NAME <b>Arnold Ellebracht</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Kukuk</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Leo M. Ellebracht</b>		Address <b>3553 Brown Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>11:20</b> a.m. <b>p.m.</b> Month, Day, Year <b>Nov 1961</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Nov 1961</b> to <b>Oct 30, 1962</b> and last saw her him alive on <b>Oct 30 1962</b> Death occurred at <b>11:20 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>James C Redington M.D.</b>		22b. ADDRESS <b>Clayton 5 Mo 950 Francis Blvd</b>	
22c. DATE SIGNED <b>10-31-62</b>		22d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11/3/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery Asso.</b>	
24. FUNERAL DIRECTOR <b>Collier Mortuary, St. Ann, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-1-62</b>	
26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>			

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

USE BLACK INK

OR TYPEWRITER RIBBON

VS 300  
Rev. 4/59

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TO

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Sheldon Collier*

Licensed Embalmer No.

*3382*

P. O. Address

*St. Ann Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.